Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3923ADA	A. BUILDING _____ B. WING _____	C 12/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCARE NEVADA WOMEN & CHILDRENS CAMPU	5659 DUNCAN DRIVE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comment The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. This Statement of Deficiencies was generated as a result of the Complaint Investigation conducted on your facility on 11/9/10 and completed on 12/21/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 130 residential program beds for the treatment of abuse of alcohol and drugs. Complaint #NV00026820 was not substantiated. The facility was found to not be responsible for and reacted appropriately to a cluster of viral meningitis cases in the facility through document review, staff interview and observations. Complaint #NV00026820 was initiated by the Bureau of Healthcare Quality and Compliance on 11/9/10. The investigation into this cluster of four viral meningitis cases included: - Review of the facility's infection control policies, staff meeting minutes, and cleaning charts and schedules. - Interviews were conducted with the Deputy Administrator, Program Director, Supervisors and one of the infected clients	D 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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D 000	Continued From page 1 - Observations were made of public hallways, cafeteria, common meeting rooms, public restrooms, baby changing stations and all infected client's bedrooms and bathrooms for adherence to the Centers for Disease Control (CDC) guidelines.	D 000		